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ABSTRACT

In many urban centers, responding to mentally ill people has become a large part of the police peacekeeping function. This article highlights the police role in handling mentally ill persons. Law enforcement options are discussed, including both formal and informal options. It is noted that officers decisions to hospitalize, arrest, or deal with a mentally ill person informally are based less on the degree of symptomatology than on the demands and constraints of the situation. Mental health professionals have commented on what some observers believe is the criminalization of mentally disordered behavior and have speculated that persons who were previously treated within the mental health system are increasingly being shunted into the criminal justice system. Implications of criminalizing mental illness are discussed and policy recommendations are made for the criminal justice and mental health systems. (Contains 12 references.) (GCP)

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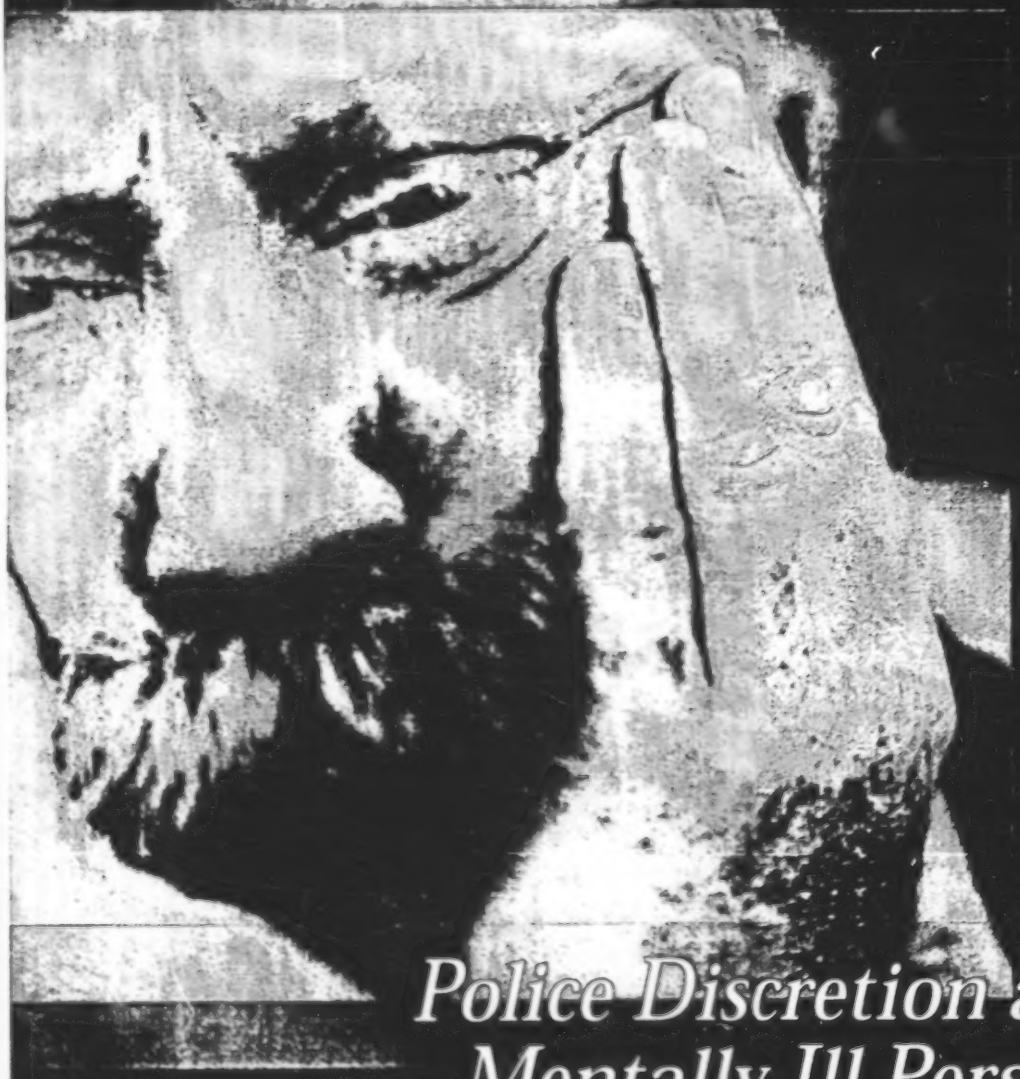

Police Discretion and Mentally Ill Persons

By Linda A. Teplin

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Linda A. Teplin is Professor of Psychiatry and Director of the Psycho-Legal Studies Program at Northwestern University Medical School. In addition to her work on the criminalization of mentally ill persons, she has conducted research on the epidemiologic characteristics of adult jail detainees, delinquent youth, and the correlates of violence. Her current work involves the first large-scale, longitudinal study on psychiatric disorders, patterns of service use, and risky behaviors.

In many urban centers, responding to mentally ill people has become a large part of the police peacekeeping function. Several factors have increased the likelihood of police encounters: deinstitutionalization in the 1960's, cutbacks in Federal mental health funding, and changes in the legal code governing patient rights and affirming the right of a mentally ill person to live in the community without psychiatric treatment.[1]

At the same time, society's tolerance of mentally ill persons in the community is limited. Given the stereotype of mentally disordered people as dangerous,[2] citizens often call upon the police to "do something" in situations involving mentally ill individuals, particularly when they exhibit the more frightening and disturbing signs of mental disorder.[3]

The Police Role in Handling Mentally Ill Persons

Police involvement with mentally ill persons is grounded in two common law principles: (1) The power and responsibility of the police to protect the safety and welfare of the public, and (2) *parens patriae*, which dictates protection for disabled citizens such as mentally ill persons.

Most mental health codes specify the parameters of police involvement with mentally ill persons and instruct police to initiate a psychiatric emergency apprehension whenever the person is either dangerous to self or others or is unable to provide for basic physical needs so as to protect him/herself from serious harm.

Although the law legitimizes the police officer's power to intervene, it does not—and cannot—dictate the officer's response in any given situation. As with all law enforcement decisions, the police must exercise discretion in choosing the most appropriate disposition.

Officers who encounter an irrational person creating a disturbance have three choices: transport that person to a mental hospital, arrest the person, or resolve the matter informally. In making these judgments and in trying to calm situations on their own, the police are called upon to act as "street-corner psychiatrists."

But their options are, in practice, limited. Initiating an emergency hospitalization often is fraught with bureaucratic obstacles and the legal difficulties of obtaining commitment or treatment. In addition, many psychiatric programs will not accept everyone, particularly those considered dangerous, those who also have substance abuse disorders, or those with numerous previous hospitalizations.[4] (See "Law Enforcement Options for Handling Mentally Ill Persons," page 10.)

Officers who encounter an irrational person creating a disturbance have three choices: transport that person to a mental hospital, arrest the person, or resolve the matter informally.

Officer Decision Making Regarding Mentally Ill Persons

The seminal study of police officer decision making regarding encounters with mentally ill citizens was Egon Bittner's in 1967.[5] Bittner found that the police reluctantly made psychiatric referrals and initiated hospitalization only when the individual was causing or might cause serious trouble. Even so, officers resorted to a mental hospital only in the absence of other alternatives.

Almost 15 years later, a study by the author of this article found that little had changed. In 1980, researchers began recording first-hand observations about how police officers handled mentally disordered persons in a large northern city and how these interactions differed from interactions with people who were not mentally disordered.[6]

They found that police resolved situations informally in 72 percent of the cases, made an arrest in 16 percent of the cases, and initiated emergency hospitalization in 12 percent of the cases.

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Law Enforcement Options for Handling Mentally Ill Persons

Law enforcement officers have two basic ways to respond in situations involving mentally ill people who are causing a disturbance: formally (either hospitalization or arrest) or informally.

Officers' decisions to hospitalize, arrest, or deal with a mentally ill person informally are based less on the degree of symptomatology than on the demands and constraints of the situation. Officers' first choice is usually informal disposition.

Formal Options

Hospitalization. Police use of hospitals is limited by the number of psychiatric beds in the community and by the criteria for admission. Virtually every officer in the study was aware of the stringent requirements for admission into the local psychiatric hospital: Individuals had to be seriously ill—for example, be actively delusional or suicidal. Police knew that persons who were mentally retarded, alcoholic, or categorized by hospital staff as "dangerous" often were not welcome at the hospital, nor were persons with criminal charges pending, no matter how minor.

Furthermore, handling mentally ill persons was not regarded by officers as a "good pinch" and was largely unrewarded by the department, further deterring psychiatric referrals. In addition, officers perceived the rapid deinstitutionalization of mentally ill persons as a personal slight on their judgment and a sign of the hospital's unwillingness to "do something."

Still, occasionally the police did take someone to the hospital, as shown in the following scenario:

> We were on the scene in less than a minute. The citizen in question was a black male, about 45 years old, standing on the sidewalk with his arms outstretched, spinning around in circles.... The officer and the sergeant got the man to stop spinning. They attempted to question him, but the man was completely out of it. He gave no indication that he understood what was going on. He didn't talk at all during the encounter. The officer called for a wagon to take the man to the hospital.

Arrest. While arrest was not a frequent disposition, the arrest rate for persons exhibiting signs of mental illness was greater than that of other citizens involved in similar types of incidents. Arrest often was the only step available to the officer in situations where individuals were not sufficiently disturbed to be accepted by the hospital, but were too public in their deviance to be ignored.

It was common for an officer to obtain a signed complaint in situations where he or she thought an individual required hospitalization. The aim was to ensure the ready availability of an alternative disposition—arrest—in the event that the hospital found the individual unacceptable for admission. The officers' apparent ingenuity was borne out of necessity since hospital admission criteria were so stringent. A typical example:

> The officer said this man had been on the street calling women names, calling them whores, and shouting at black people, calling them names and chasing them.... A woman had signed a complaint for his arrest because he was bothering her. The man sounded like a paranoid schizophrenic.... He was very vague about himself and who he was and felt that people were out to get him.... When he was taken to his cell, he began shouting to be let out and he kept shouting.... He was charged with disorderly conduct. The officer said there wasn't enough to take him into the mental health center because his behavior wasn't that severe for the hospital to accept him.

Likewise, when an individual was defined as "too dangerous" by the hospital, arrest was the only alternative available to the officer:

> A young man was banging on his mother's door with a meat cleaver.... He was threatening to kill someone else and wanted to get into his mother's home for a gun. She wouldn't let him in and had called the police to get rid of him and/or to calm him down. When the police got there, officer II decided the man needed to be hospitalized as he was dangerous to himself and others. So they called for a wagon to take the man to the mental health facility...but they also wanted a complaint signed by the mother for disorderly in case [the hospital wouldn't take him]. It turned out that the hospital would indeed not take the man, so he ended up being locked up for disorderly.

Ironically, it was precisely the requirements for emergency psychiatric detention set forth in most mental health codes—"dangerous to self and others"—that rendered mentally disordered citizens undesirable to hospitals and resulted in their arrest.

Persons whose symptoms crossed the boundaries of the caretaking systems met a similar fate. Mental health programs found persons with alcohol problems disruptive to the patient environment and often would not accept them for treatment. Conversely, detoxification facilities felt they were not equipped to deal with persons exhibiting signs of mental disorder and would turn away persons with such mixed symptoms. In general, jail became the place of last resort. Because mental health

and substance abuse systems tended to design their programs as though clients were "pure types," a number of people were unacceptable for treatment in any health care facility.

The seriousness of an incident also helped to determine the disposition. This did not always mean the seriousness of the offense. For example, situations in which the citizen was disrespectful of the officer were nearly always thought to be "serious." So were situations that were public, offended "decent" people, and had a willing complainant. For example, an elderly woman told police that a man sleeping in a car behind her apartment building had acted crazy the night before and had thrown rocks at the building. It looked as though the man had cut off all his hair, injuring his head in the process, and he was disoriented and filthy. The police told him he would be booked for property damage and probably disorderly conduct.

In sum, the police resorted to arrest in three types of situations:

- When an individual was thought to be either unacceptable to the hospital or when his or her symptoms made him fall through the cracks of various caretaking systems.
- When public encounters exceeded the community's tolerance for deviant behavior.
- When the police felt it was likely that the person would continue to cause a problem if something were not done.

In general, police made a formal disposition—hospitalization or arrest—when the situation, if unchecked, would escalate and require further police assistance. The large grey area between behavior that is mentally disordered and that which is merely disorderly allows officers a great deal of discretion in choosing the disposition. The seriousness of psychiatric symptoms is only one of the determining factors.

Informal Options

Informal dispositions require neither paperwork nor unwanted "downtime"—hours off the street. Emotionally disturbed people who were likely to be handled by informal means were categorized as neighborhood characters, troublemakers, and quiet, unobtrusive "mentals."

Neighborhood Characters. Neighborhood characters were persons whose idiosyncrasies were well known to police in their precinct. Virtually any officer could talk about "Crazy Harry," "Batman," or "Mailbox Molly." These were neighborhood characters who were defined by police as "mentals" but who were never hospitalized because they were known quantities. Police had certain expectations regarding the parameters of their behavior. As a consequence, the police tolerated a greater degree of deviance from them. More important, officers' familiarity with each citizen's particular symptoms enabled them to "cool them out," making an informal disposition that much easier. The following is a rather common encounter of this type:

> There's a lady in the area who claims she has neighbors who are beaming rays up into her apartment. The officer said he usually handles the situation by telling her, "We'll go downstairs and tell the people to stop beaming the rays," and she's happy. The officer seemed quite happy about this method of handling the problem. He could do something for the lady, and even though it's not the same kind of assistance he might give another type of situation, he could allay the lady's fears by just talking to her.

Troublemakers. If an emotionally disturbed citizen has been labeled a "troublemaker," hospitalization or arrest is very unlikely. Intervention in such cases is considered not worth the trouble. An example was a woman rejected by the mental hospital, who, "whenever she came into the station, caused an absolute disruption. She would take off her clothes, run around the station nude, and urinate on the sergeant's desk. Officers felt it was such a hassle to have her in the station and in lockup that they simply stopped arresting her."

Quiet, Unobtrusive "Mentals." Persons whose symptoms of mental disorder are relatively unobtrusive are likely to be handled informally. They offend neither the populace nor the police with obvious manifestations of their illness, and their symptoms are not considered serious enough to warrant hospitalization. Moreover, quiet "mentals" are considered more disordered than disorderly and so are unlikely to provoke arrest.

Through officers' experiences with neighborhood characters, they know just how to soothe the emotionally disturbed person, to act as a "street-corner psychiatrist." In this way, they help to maintain many mentally ill people within the community and make deinstitutionalization a more viable public policy.

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Since the study in the early 1980's, the author has conducted two subsequent studies to determine the prevalence rates of mental disorder in male and female adult jail detainees.[7] In the subsequent studies, nearly 9 percent of male detainees and more than 18 percent of female detainees met the criteria for a lifetime severe mental disorder (schizophrenia or major affective disorder).

A number of mental health professionals have commented on what some observers believe is the "criminalization of mentally disordered behavior"[8] and have speculated that persons who previously were treated within the mental health system increasingly are being shunted into the criminal justice system.[9] Perhaps in response to this outcry, a number of professional organizations—the American Bar Association and the National Coalition for Jail Reform, for example—sought to develop innovative policy guidelines and/or alternatives to handle mentally ill persons within the criminal justice system.

It is plausible to imagine that criminalization of mentally ill persons may be occurring. Given all the bureaucratic and legal roadblocks to making mental health referrals, the police might see arrest as a simpler and more reliable way of removing an individual from the community. Those rejected as inappropriate by the mental health system must be accepted by the criminal justice system, which does not have the luxury of turning away clients.

Consequently, jails and prisons may have become the long-term repository for people with mental disorders. (See "Many Arrestees in Lockups Are Mentally Ill," page 14.)

However, the criminalization hypothesis has been based largely on intuition and casual observation. Research is not definitive. Of the 1,798 citizens involved in the observational study of police-citizen encounters discussed above, 506 (28 percent) were considered by the police to be suspects in a crime, and of these, 148 were arrested.

The probability of being arrested was 67 percent greater for suspects exhibiting signs of mental disorder than for those who apparently were not mentally ill. Fourteen of the 30 mentally disordered suspects, or 47 percent, were arrested, compared to 133 of the 476 other suspects, or 28 percent. (See table 1.) Clearly, mentally ill citizens in the study were being treated as criminals.[10]

Table 1: Relationship Between the Presence of Mental Disorder and Arrest

	Percent of Mental Disorder		
	No	**Yes**	**Total**
Arrest			
No	343 (72%)	16 (53%)	359 (71%)
Yes	133 (28%)	14 (47%)	147 (29%)
Total	476 (94%)	30 (6%)	506 (100%)

Chi-Square = 4.801 with 1 degree of freedom
$p < .05$
Chi-Square (corrected for continuity) = 3.936 with 1 degree of freedom
$p < .05$

Explanations for a Higher Arrest Rate

Several explanations are possible for the higher arrest rate among persons who exhibited signs of serious mental illness, including, in part, that officers lacked knowledge of the symptoms of severe mental disorder. Many mental disorders are associated with a number of disconcerting symptoms. Although some symptoms, such as verbal abuse, belligerence, and disrespect, are not themselves against the law, such behaviors may provoke an officer to respond more punitively.

Also, as a result of the severe reductions in mental health services—both inpatient and outpatient—the criminal justice system may have become the default option for dealing with individuals who cannot or will not be treated by the mental health system.

That the criminal justice system is the default option is borne out of the common police practice of obtaining a signed complaint against an individual thought to need psychiatric hospitalization so that officers can arrest him if the hospital finds him unacceptable for admission. It also is evident in the arrest of persons with mixed symptoms. Police officers often make the rounds of service agencies—from the halfway house to the hospital to the detox center—before resorting to arrest.

Implications of Criminalizing Mental Illness

The evidence that mentally ill persons are being criminalized is of concern because the criminal justice system is not designed to be a major point of entry into the mental health system. An arrest labels a mentally ill person as "criminal" and may doom that person to be arrested in cases of

future disorderliness. And once incarcerated, jail hardly is an ideal treatment center for mentally ill persons. The cacophony of the jail setting works against even the recognition of mental disorder.

If the criminal justice system has indeed become the point of entry for psychiatric treatment, budget cuts in the mental health area simply shifted the financial burden to jails and prisons.

Policy Recommendations

The findings that mentally ill people are being criminalized suggest the need for several changes in both the criminal justice and mental health systems:

- The public mental health system must evolve to meet the challenges of deinstitutionalization. Policymakers must recognize the need for significant increases in funding for mental health services in the community. The public mental health system and the criminal justice system must collaborate so that police officers have several alternatives, not just arrest or hospitalization, when handling mentally ill persons in the community.
- A more integrated system of caregiving must be designed to reduce the number of persons who fall through the cracks into the criminal justice "net" and to provide effective community services to persons who are arrested and released.
- The least restrictive alternative should be used, and whenever possible, mentally ill persons with misdemeanor charges pending should be treated in a mental health facility. The latter recommendation is consistent with that of the American Bar Association guidelines.[11] In this way, mentally ill individuals would not become victims of their own disorder unless they commit serious crimes.
- Police officers must receive adequate training in recognizing and handling mentally ill citizens so that individuals who are more disordered than disorderly are referred to the appropriate system. The police also must have a clear set of procedures to handle such persons, including negotiated "no-decline" agreements with hospitals. Such agreements would give police a designated place to take apparently mentally ill citizens. These agreements also are vital for establishing a successful liaison between the police department and the mental health system and ending the refusal of hospitals to treat some people.

Although these recommendations require an increase in levels of funding, such a plan is likely to be financially prudent in the long term. Certainly, deinstitutionalizing the mentally ill with only the barest of community-based support did not decrease the need for treatment.[12] We may simply have shifted the burden (and the costs) from the mental hospital to the jail.

Despite this trend, policies have reduced both funding levels and Federal involvement in providing funds for mental health treatment. This has had serious consequences for the deinstitutionalized person. It is likely that supporting mental health programs at current levels will increase the probability that mentally ill persons publicly exhibiting their disorder will be processed through the criminal justice system.

Some jurisdictions, however, are attempting to develop innovative strategies to reduce criminalization of mentally ill persons and improve services for offenders in the community. Some initiatives are designed to prevent arrest. Others address the mentally ill person's need for referral and treatment later on in criminal justice system processing—at a pretrial hearing, during detention, or after release.

People with mental disorders must not be criminalized as a result of inadequate funding for the mental health system. A long-term commitment to funding mental health care is required so that the most appropriate and effective treatment programs may be provided within the least restrictive setting possible.

Many deinstitutionalized adults, for example, can be productive members of the community if they live in structured settings where they are encouraged to take their medications regularly. Policies must be modified and resources allocated to see that the civil rights of mentally ill persons are protected, while providing the most humane and effective treatment available.

NCJ 183455

Notes

1. Cf. *O'Connor v. Donaldson*, 422 U.S. 563 (1976); *Rennie v. Klein*, 653 F.2d 836 (3d Cir. 1981); *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980).
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Many Arrestees in Lockups Are Mentally Ill

According to the Bureau of Justice Statistics, in mid-1998 an estimated 16 percent, or 283,800, of inmates in the Nation's prisons and jails were mentally ill. Another 16 percent, or 547,000, probationers also were considered mentally ill.

The analysis may actually undercount the number of incarcerated mentally ill people since it relied on inmates acknowledging to an interviewer that they either had a mental or emotional condition or had ever been admitted overnight to a mental hospital.

State prisons hold most inmates, and mentally ill people in State prisons were more than twice as likely as other inmates to have been homeless in the 12 months prior to their arrest (20 percent versus 9 percent). They also reported far higher rates of physical and sexual abuse; almost one-third of men and more than three-quarters of women said they had been abused in the past.

Although prison and jail are not the best places to receive treatment, a large share of emotionally disturbed inmates secured psychological treatment there. Since admission, 61 percent of these inmates in State and Federal prison and 41 percent of the mentally ill in local jails reported that they had received treatment for a mental condition—either counseling, medication, or other services.

Mentally Ill Inmates and Probationers

Percent who reported...	State prison	Federal prison	Jail	Probation
Mental or emotional condition	10%	5%	11%	14%
Overnight stay in a mental hospital	11%	5%	10%	8%
Percent estimated to be mentally ill*	16%	7%	16%	16%

* Persons who reported a mental or emotional condition or an overnight stay in a mental hospital.

Source: Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers," Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1999 (NCJ 174463).

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6. Researchers observed 283 randomly selected police officers in the large northern city for 2,200 hours over a 14-month period during 1980–81. Excluding traffic stops, the data included 1,072 police-citizen encounters involving 2,122 citizens. Of the citizens involved in these encounters, 85 in 79 encounters were defined by the researchers as mentally disordered.

   The field researchers ascertained the presence of mental disorder with a symptom checklist that listed the major characteristics of severe mental illness—for example, confusion/disorientation, withdrawal, unresponsivity, paranoia, inappropriate or bizarre speech and/or behavior, and self-destructive behaviors. The field observers defined a person as being mentally disordered if he or she possessed at least one of these traits and met a common-sense standard for mental illness. For example, a streetperson who was found by the police to be shouting and running down the street naked on a cold night in January would have been coded as being mentally disordered. However, similar behaviors exhibited on a warm June evening by a group of drunken college students would be recognized as bizarre, but not indicative of mental disorder. See Teplin, L.A., *Keeping the Peace: The Parameters of Police Discretion in Relation to the Mentally Disordered*, Research Report, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, April 1986 (NCJ 101046).

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For More Information

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